Indian Health Service

OIT Updates

GAIL TOWNSEND

IT SPECIALIST

MARCH 12-24, 2024

OIT – Practice Management

Priority development work

Health Data, Technology and Interoperability (HTI-1)

- Demographic changes for HTI-1

HealthShare upgrade to IRIS for Health

- BPRM v4 patch 3

Planning and preparing Project Work Authorization for FY2025

Technical Advisory Meeting for Registration – meeting to help plan for Registration updates for FY 2025.

Health data, Technology and Interoperability (HTI-1)

Health data, Technology and Interoperability (HTI-1)

US@ Project– Patient Address formatting

Phase 1 – delivered in BPRM v4 patch 4

Street Address line 1 format correction

INCORRECT	CORRECT
123 EAST MAIN STREET	123 E MAIN ST
POST OFFICE BOX 444	PO BOX 444
GEN DEL	GENERAL DELIVERY

Health data, Technology and Interoperability (HTI-1) cont.

US@ Project– Patient Address formatting

Phase 2 – BPRM v4 patch 5-6

Research on purchasing a standard city and zip code file

Updating historical addresses with new format

Implementing Canadian and Mexico addresses

Line 0 for a Business Address for patients in nursing home

Health data, Technology and Interoperability (HTI-1) cont.

New data dictionary fields

Change Mother/Father to Parent/Guardian

Add new relationship field to correspond with Parent/Guardian

Tribal Affiliation: New because we may not be able to use current Tribe field as that is tied to enrolled.

Occupation: Type of work (eg IT Specialist, Business Analyst, Doctor, etc)

Occupation Industry: Type of Business (Indian Health, US Postal, Walmart, etc)

Payer Identifier: Need data source. Current RPMS use is Insurer Types which may not include all payer identifiers

Patient requested restriction: Research with other teams for best solution

Health data, Technology and Interoperability (HTI-1) cont.

Update to data dictionary files

Race/Ethnicity update to version 1.2

Birth Sex include SNOMED

Sexual Orientation/Gender Identity update SNOMED to March 2022 release

All HTI-1 work must be completed by December 31, 2025

Future Registration GUI

Text messaging for Appointment Reminders

- May require collection of phone carrier
- Consent to send text message

Registration Updates (BPRM V4 P2)
Released February 27, 2024

Feature ID	Title
92124	REG - Allow Patient Appt Check-In from Appt Tab for users with appropriate access
98704	REG – fix 'Access Date' Typo
96804	REG - Display insurer phone number to Insurance Coverage screen [INC0334503]
96030	REG - Add language proficiency & Interpreter Required required fields to Register Patient screen [INC0333759]
97607	REG - Enable Appts tab (Registration module) for non-scheduling users holding 'SDZ ELIG REPORT' Key
97269	REG - Display Record Flag narrative/details in Patient Profile so that all Registration users can see the details information
96762	REG - Context menu of an appointment for a prohibited clinic, not assigned to the user, should not be blank [INC0338149]
97859	REG - Display appts across all Divisions on Appts Tab in Registration module [INC0346495]
62330	REG - Include advance directive and notice of privacy practice to error/warnings [CR_12272]
92841	REG - Make 'copy Emergency Contact' & 'copy Next of Kin' more user intuitive on Patient Profile
97439	REG - PPN - Save patient preferred name in UPPERCASE only
96201	REG - Allow users with 'SDZ ELIG REPORT' Key to print appt Letters, on Patient Appt tab, for users with no scheduling access
99222	REG - Make NPP & Veteran data entry more user intuitive
95990	REG - Fix the issue with 'Updating name for ER contact or NOK deletes all other info' [INC0333559]

Registration Updates (BPRM V4 P4)
Released February 27, 2024

ID	Title
99780	BPRM - REG/SCH - Include modifications required for the US@ Project Certification
96760	BPRM - REG - Display Person Code [INC0337802]
97261	BPRM - REG - Prevent selecting Inactive Communities but Display in patient history
100749	BPRM - REG - Provide ability to Add a Guarantor for patient NOT registered [INC0362649]
99986	BPRM - REG - Provide a Temporary Chart Number Report
62510	BPRM - REG - Display patient waitlist entries for ALL clinics where the patient appears [CR_8072]

Registration (AG) limited development

ID	Title
106260	AG - Include modifications required for the US@ Project Certification
74989	AG - MSP 90 day error/warning for Medicare Advantage Plans
101343	AG - Guarantor entry program error <SYNTAX>FINDGUAR+12^AGINS [INC0362649]
100746	AG - Patient Consent to Release of Information - for Certification
75513	AG - Print field audit report (ERP) program error [CR_9260]
97438	AG - Patient Preferred Name field Uppercase entry only
94511	AG - Fix invalid MSP and Language Errors/Warnings
74990	AG - Eligibility limit for pregnancy and adopted under 18 notice/warning
94420	AG - Add CELL Phone# to Index Card
77067	AG-Private Insurance P4 Edit Policy Holder's Address - Fix Label Misspelled
61995	AG - Parameter for Other Tribes
80424	AG - Remove Eligibility Criteria from Emergency Contact Warning Message
62342	CR_11072 - AG - policy member DOB field needed in Policy Holder file
62341	CR_10560 - AG - Additional field to capture legal guardian or parent/parent Type.
62340	CR_10558 - AG - Benefits Coordinator Overall Status to include INELIGIBLE, Non-compliance and Failure to Comply
62336	CR_10512 - AG - HEAT182553-Info required to bill Medi-Cal for an Infant using the Mothers ID#
62334	CR_5489 - AG - Increase character limit of Tribal Enrollment # field BPRM CR 12271
60970	CR_10555 AG - Expand field for group name/group number

Disable Address fields formatting will not be available in RPMS Registration this is part of US@ project

OIT Management will decide on the future of RPMS Registration development

New technology is limited for RPMS

QUESTIONS AND FEEDBACK


INDIAN HEALTH SERVICE
PHS · 1955 ·

Health IT Modernization for Patient Registration

OFFICE OF INFORMATION TECHNOLOGY
ADRIAN LUJAN, CPB
MARCH 14, 2024

A New What?

- This will affect all users of the IHS Resource Patient Management System (RPMS)
- RPMS will be replaced by a new Electronic Health System
  - Oracle Cerner is the selected vendor
- Impacts all IHS Federal facilities and tribal/urban locations who have signed a letter of intent to move to the new HER
- Ongoing and will begin implementing in two facilities by the end of 2025
  - 1 federal Hospital
  - 1 Ambulatory Care facility
- Why?

What does this mean for me?

- Sites that use BPRM (GUI Registration/Scheduling/ADT) versus using Roll-and-scroll
- RPMS will become the legacy EHR
- We will need to standardize our processes – more to come
- What else?

How do I Prepare?

- Attend the WRAP sessions hosted by David Taylor (OIT) and the modernization team
- Form and participate in an implementation team
- Be aware of what other departments are doing
- Hire additional staff
- Measure your productivity
- Participate in the Technical Advisory Groups (TAG)
- Participate in the ECG, if selected

RPMS

- Inactivate patient records
  - Follow guidance from the Indian Health Manual (D-9)
  - *A facility may inactivate a health record three to seven years after the patient's last episode of care.*
  - Deceased patients
- Insurance Eligibility
  - Update and closing coverage

RPMS (con't)

- Review CHS Status
  - Research and determine CHS status for *Pending* patients
  - RPMS Billing does not generate a Non-Ben claim for pended patients
- Insurer file clean up
  - Make sure to include Business Office, PRC, POS and finance
  - Inactivate old insurers, correcting the insurer type

What else??

PGEN Pending Report

```
 PCC MANAGEMENT REPORTS PATIENT LISTING
                                SUMMARY PAGE

REPORT REQUESTED BY: LUJAN,ADRIAN M

PATIENT Selection Criteria
     Eligibility Status:  PENDING VERIFICATION

REPORT/OUTPUT TYPE
     Detailed Listing containing
     Chart #  (11)
     Patient Name  (20)
     Eligibility Status  (18)
     Patient's Last Visit  (12)
              TOTAL column width: 69

Patients will be SORTED by:  Name/Chart #/SSN
```

```
 PCC PATIENT LISTING                  Page 1
HRN          NAME                   ELIGIBILITY          LAST VISIT
-------------------------------------------------------------------

IHH 123987   APPLE,GOLDEN           PENDING VERIFICATI   JUL 23, 2007
IHH 211201   BEAR,BABY              PENDING VERIFICATI
IHH 211200   BEAR,MOMMA             PENDING VERIFICATI   APR 12, 2006
IHH 355111   BEAR,PAPA              PENDING VERIFICATI   APR 12, 2006
IHH 978321   BING,CHERRY            PENDING VERIFICATI   JAN 16, 2012
IHH 12714    BRAVO,JOHNNY           PENDING VERIFICATI
IHH 23444    BROWN,JAMES            PENDING VERIFICATI   JAN 23, 2006
IHH 31387    BUNNATT,JOSEPH A       PENDING VERIFICATI
IHH 55663    CHAVES,CARLEE          PENDING VERIFICATI   FEB 07, 2007
IHH 33086    CUMENCHA,ROFERD DEAN   PENDING VERIFICATI
```

Data Migration

Data Migration

- Patient Data
  - Patient Name – Correct format
  - DOB – Accurate dates
  - Mailing Address – Correct use of Line 1 and Line 2
  - More to come…
- Clinical Information

STANDARDIZATION

Contact

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  Revenue Cycle Informaticist

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Indian Health Service

Data & Graphs

K DEMPSEY, MHSA

MANAGEMENT ANALYST

MARCH 2024

Topic Outline

Quality Improvement (QI) Explained

Training

Data Gathering

Policy & Implementation

Monthly Reports

Weekly Reports

Strategic Plan

Moving Forward- Highlights & Challenges

QI-Explained

"If you wouldn't write it and sign it, then don't say it."

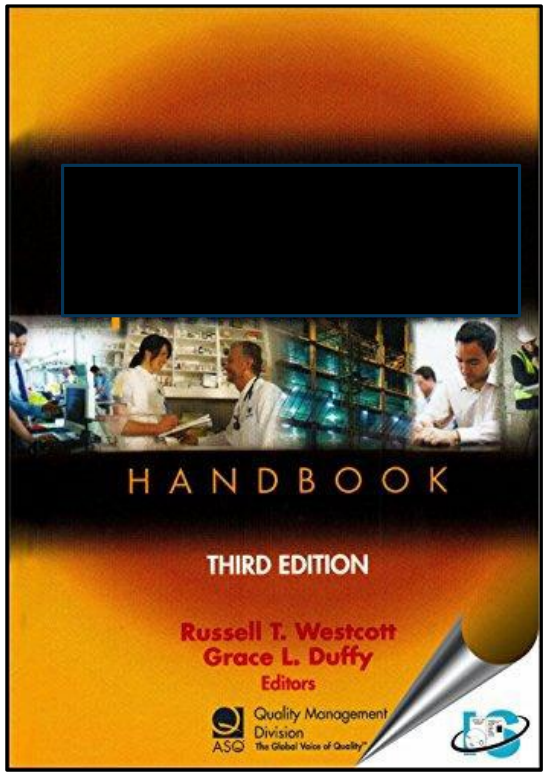
-Earl Wilson, Author and Columnist

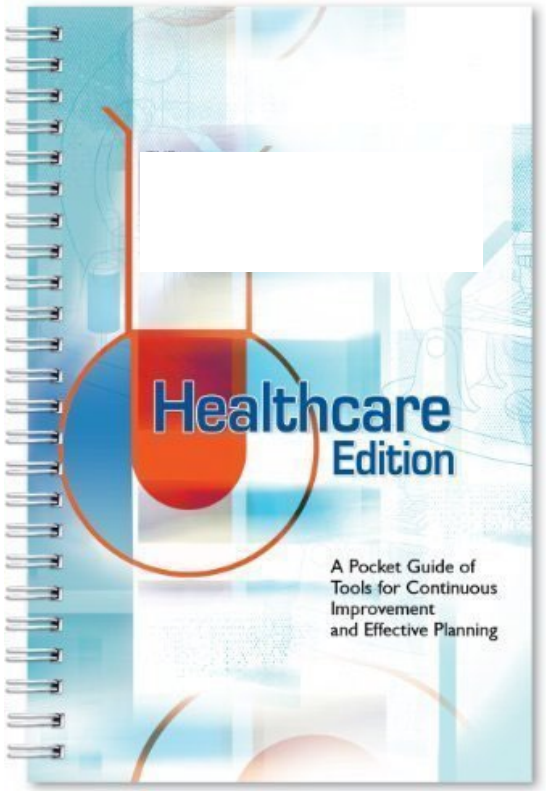
QI 101-Training

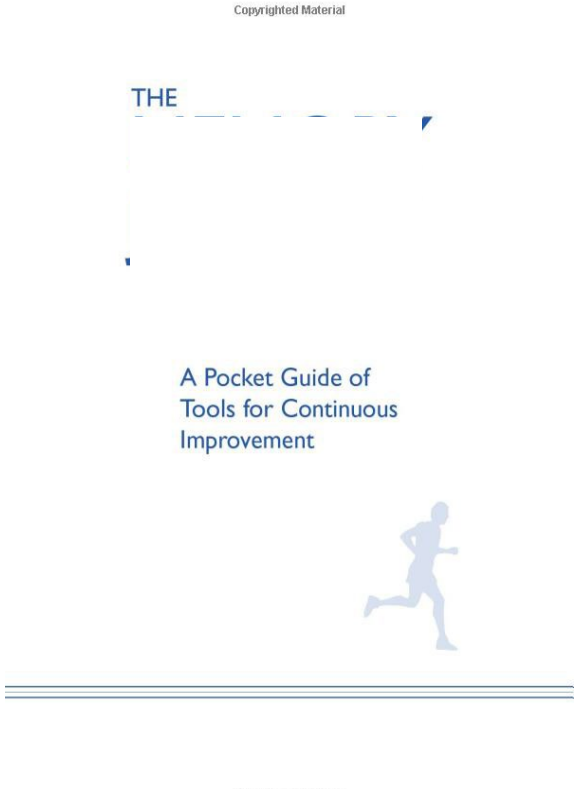
Quality 101 training made available or requirement for staff at areas

Quality 101 and Improvement Training with certifications

Training


HANDBOOK
THIRD EDITION
Russell T. Westcott
Grace L. Duffy
Editors
Quality Management Division
The Global Voice of Quality


Healthcare
Edition
A Pocket Guide of
Tools for Continuous
Improvement
and Effective Planning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THE
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Improvement

Training

Session One

- Introduction to QI
- Background of QI
- Quality Concepts
- Team Basics
- Continuous Improvement Techniques

Session Two

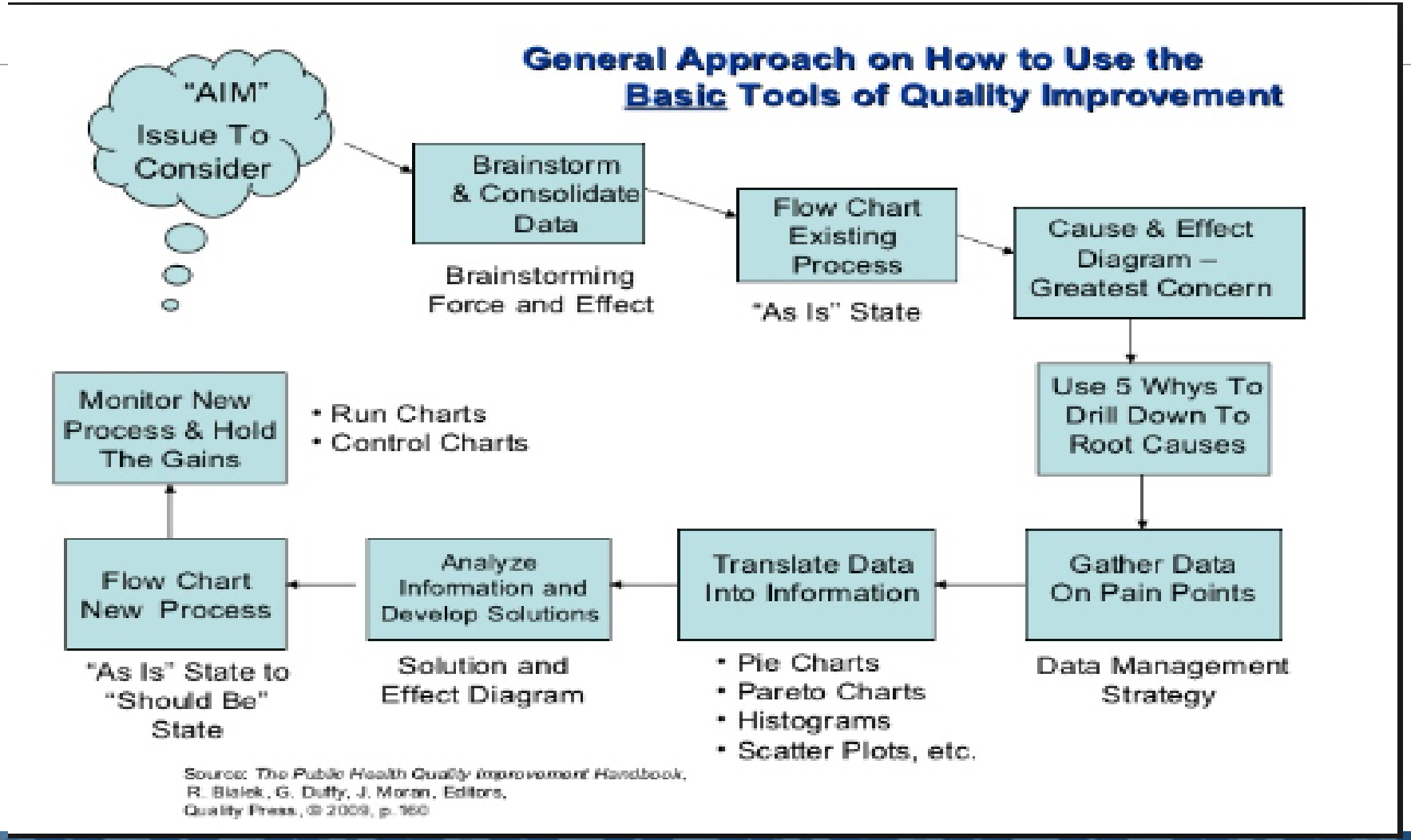
The Process Improvement Tool Kit

- Plan, Do, Check, Act
- Brainstorming and Force Field Analysis
- Cause and Effect Diagram & 5 Whys

Team Process Improvement Projects

- Team Applications
- Team Worksheets

Training


General Approach on How to Use the Basic Tools of Quality Improvement
"AIM" Issue To Consider
Brainstorm & Consolidate Data
Brainstorming Force and Effect
Flow Chart Existing Process
"As Is" State
Cause & Effect Diagram – Greatest Concern
Use 5 Whys To Drill Down To Root Causes
Gather Data On Pain Points
Data Management Strategy
Translate Data Into Information
• Pie Charts
• Pareto Charts
• Histograms
• Scatter Plots, etc.
Analyze Information and Develop Solutions
Solution and Effect Diagram
Flow Chart New Process
"As Is" State to "Should Be" State
Monitor New Process & Hold The Gains
• Run Charts
• Control Charts
Source: The Public Health Quality Improvement Handbook, R. Bialek, G. Duffy, J. Moran, Editors, Quality Press, © 2009, p. 160

QI-Data Gathering

First Assignment: Identify One improvement initiative

1. Flow Chart
2. A3 Improvement Plan-complete for one improvement initiative
3. Run Chart-use the NAO Data Analysis Template to support your selected initiative
   What is your analysis-write a description
   Identify how you will make improvements based on your analysis

   Use the Plan, Do, Study, Act Model Principle

4. SIPOC FORM-complete for the initiative you are working on

   Complete a Flow Chart Process Diagram

5. Include Other QI Tools you have used to do to improve your work

Important!

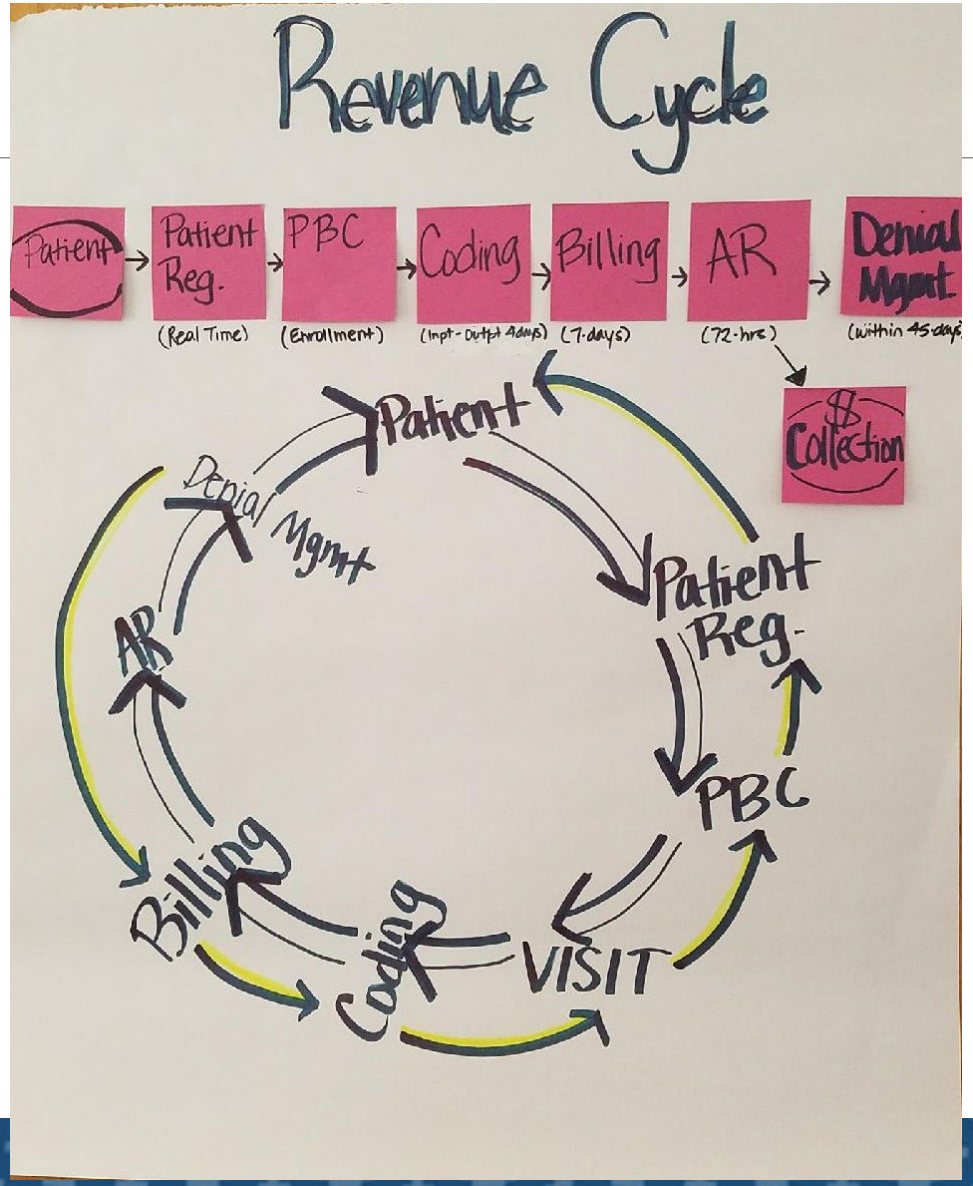
Incorporate improvement and results-oriented in your work. Be disciplined

in your improvement work.

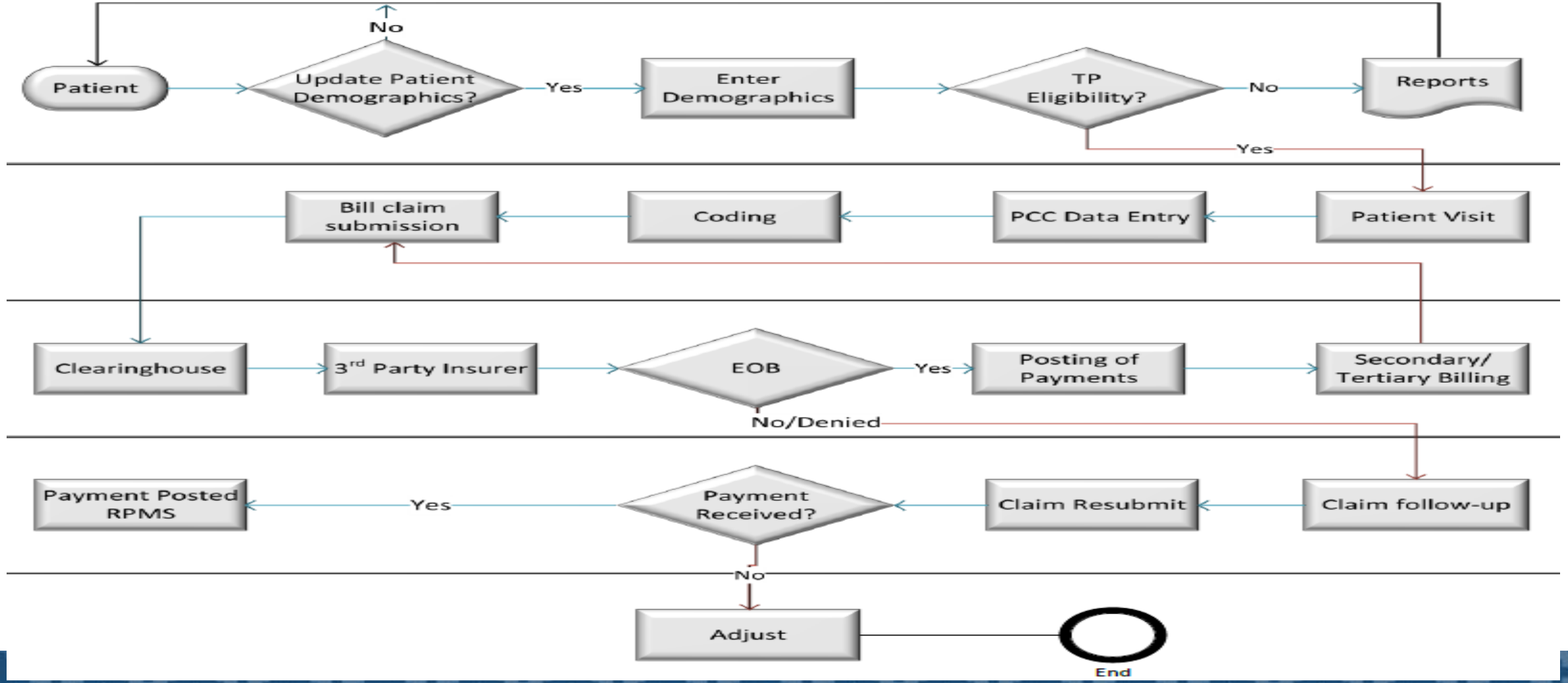
Your work always supports patient care.

Flow Chart

Flow Chart


Revenue Cycle
Patient
Patient Reg.
PBC
Coding
Billing
AR
Denial Mgmt
(Real Time)
(Enrollment)
(Inpt - Outpt 4days)
(7 days)
(72 hrs)
(within 45 days)
Collection
Patient
Patient Reg.
PBC
VISIT
Coding
Billing
AR
Denial Mgmt

Flow Charts


Patient
Update Patient Demographics?
No
Yes
Enter Demographics
TP Eligibility?
No
Reports
Yes
Patient Visit
PCC Data Entry
Coding
Bill claim submission
Clearinghouse
3rd Party Insurer
EOB
Yes
Posting of Payments
Secondary/ Tertiary Billing
No/Denied
Claim follow-up
Claim Resubmit
Payment Received?
Yes
Payment Posted RPMS
No
Adjust
End

A3 Form

A3 Form

Department/Service Name: Finance

A3 Improvement Plan

BACKGROUND

- The NAIHS BO needs report standardization to improve upon analysis, monitoring, documentation, managing, understanding, and revenue generation within PR, PBC, Coding, Billing, Posting, and Denial Management per IHS Office of Resource and Partnerships

CURRENT CONDITIONS

- SUs and BO are not monitoring and analyzing the same data within the same BO from SU to SU. Some SU BOMs are not transparent with reporting data.
- Some SU BOMs are not identifying improvements needed
- Some SU BOMs are not analyzing data to improve their sections
- SU BO Report Standardization Meeting Issues/Findings:
  - VIS report revealed verification being completed on the back end.
  - Patient registration MSAs and Clinical MSAs not completing registration
  - VIS report shows Part A visits totaling a potential loss of $10 million+ in FY 2016 and FY 2017 due to no inpatient care component

- Patient Registration section needs to verify patient demographics at every encounter
- Patient Benefit Coordinator need to assist every patient in enrolling on some type of alternate resource and educate on the ACA
- Coding is entered within 4 days of Date of Service (DOS)
- Billing Third Party Claims within 7 days
- Accounts Receivable – Posting of Payments within 3 days from receipt of batching
- Denial management will have to follow-up within 45 days of batching

ANALYSIS

- The BO Strategic Plan has the different BO sections that include Goals, Training Needs, Productivity Goals, Quality Goals, Risk Assessment, Opportunity to Capitalize On, and Efficiency.

PROPOSAL

- Schedule a follow-up meeting to assist with any reports or questions
- Sharon Brokeshoulder to provide templates for Billing PD, PIP, etc.
- Request PCC RPMS access for BOM at FCRHCC
- Review FTEs and redesign the MSAs back into the Business Office
- Review PHN visits and capitalize the Medicare Part A visits
- Review FAB-adjust and cancel bills that are over the timely filing limits in the billing queue
- Will need to follow-up with OIT to determine if the PR verifications are updating in the RPMS System when using the new version of RPMS-BPRM
- Request PD for Provider Enrollment Specialist from GIMC to implement at Chinle SU
- Follow-up with AR side regarding payments, UTLT report cleanup, and NAIHS advised a heat ticket would be sent to OIT
- Request ASUFAC for Rock Point Facility collections to be sent to the Rock Point clinic to show what Rock Point Facility is collecting
- Recommend meetings to include the BO as they are a crucial part to the Revenue Cycle

PLAN

- Identify workgroup to implement Strategic Plan and BO Report templates: Sharon Brokeshoulder, Brenda Tahe, Margaret Morgan-Benally, Marion Kelley-Jim, Gary Russell-King, and K Dempsey
- Request BO reports from SUs and review to determine possibility of changing a report for a better report.
- Implement Strategic Plan and BO Report templates at the SUs and identify timelines
- Implement reports and plans beginning April 3, 2018

FOLLOW UP

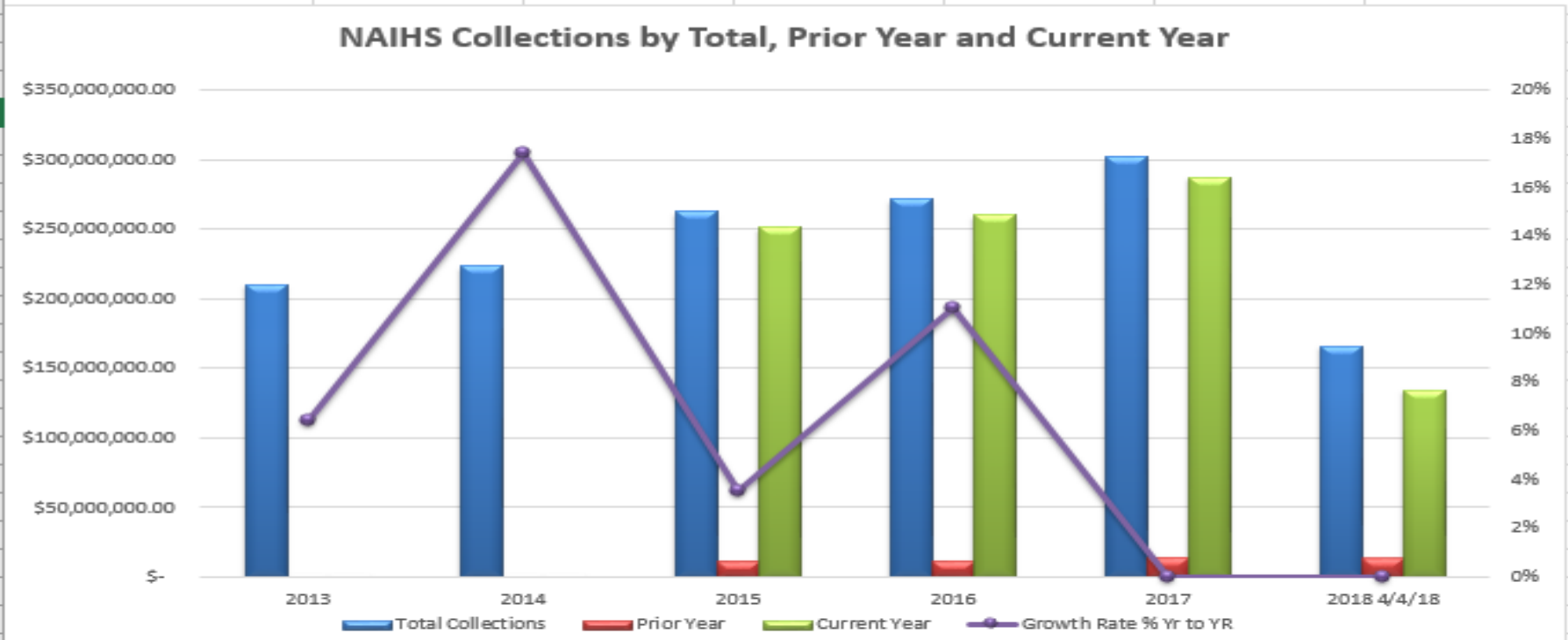
- Resistance may occur from the BOMs not wanting to implement the reports. Follow- up meetings and technical assistance will address this potential problem.

Run Chart

Run Chart

NAO Data Analysis Template

Name of Reports: NAIHS Collections; Date of Report: 3.20.18



GOAL: To Monitor Third Party Collections

Numerator: Present Year - Past Year Total Collections

Denominator: Past Year Total Collections

Report: Finance UFMS-Advice of Allowance Third Party Collections

DATA ANALYSIS:

The Growth Rate % from year to year is uncontrolled.

-2014-2015 ACA & Health Ins. Requirements

-2015-2016 ACA & HI Requirements plateau

-2016-2017

ACTIONS:

- Information will be shared with SU BOMs to review
- Share with Admin. Off.

Team: NAIHS Revenue Cycle

FY	2013	2014	2015	2016	2017	2018 4/4/18
Total Collections	$ 210,037,544.89	$ 223,565,504.96	$ 262,436,331.47	$ 271,778,421.16	$ 301,775,413.09	$ 165,931,835.89
Prior Year	-	-	$ 11,180,371.60	$ 11,492,570.68	$ 14,298,223.49	$ 13,231,732.59
Current Year	-	-	$ 251,255,959.87	$ 260,285,850.48	$ 287,477,189.60	$ 134,257,055.30
Growth Rate % Yr to YR	6%	17%	4%	11%	-	-

SIPOC

SIPOC

Project Title: Revenue Cycle Date: 3/2/18

SIPOC Process Description: Worksheet 3

Constraints:

-Lack of Training
-Backlogs
-Lack of Commitment
-Input Systems Not Working
-Fear of Change
-Real Time data capabilities from Contractors

Begins With:

PATIENT

Process/Activities:

-Patient Registration: Verifications
-Patient Benefits Coordinator: Third Party/Alternate Resource Eligibility
-Coding
-Billing of Third Party Claims
-Accounts Receivable: Batching of Payments
-Accounts Receivable: Posting of Payments
-Collections: Denial Management
-Debt Management
-Accounts Receivable: Reconciliation

Ends With:

Advice of Allowance/

Collections

Measures:

-MIS Report
-BRRP Report
-OPS Report
-FAB Report
-AGSM Report
-ACA Report
-Billed Report
-AOA Adjusted Report
-POS Adj. Report
-POS Collections
-AOA Billed
-POS Billed
-EHRD
-EHR
-AOA

Inputs:

-UFMS
-RPMS
-EHR/PHR
-Clearinghouse
-Patch Updates
-Manual Logs
-Third Party Portals
-PNC
-FBIS
-Contracts

Outputs:

-Report Metrics
-Objectives
-Standardization
-Productivity
-Analysis
-Transparency
-Quality Data
-Customer Service
-Accountability
-Quality Care
-Controlled

Suppliers:

-Patient
-IT
-CAC
-HIM
-Nursing
-Finance
-Acquisitions
-Providers
-BO
-OEH
-PRC
-Supply Management
-Third Party Insurers
-Contractors

Customers:

-Everyone within the Revenue Cycle also including-

Administration
Staff HQs
Contractors Navajo Nation Staff

QI-Policy & Implementation

Navajo Area Business Office Internal Monthly Report Policy

Subject: **Business Office Monthly Reports**		**Revision No.** **1**
Applies to: **Business Office Reports**	**Effective Date:** **12/1/18**	**Target:** **Business Office Manager and Business Office staff**

Scope: Provide expectations and standardized reporting mechanism for the Business Office Managers (BOMs) to complete month to month reports with an analysis and trend patterns over a two-year time period, unless indicated below, for your Service Unit (SU).

Purpose: Monitor and ensure compliance within those Business Office (BO) sections at the highest level of BO operations when reporting to your SU Executive Leadership Team, Governing Body (GB) and the Navajo Area Office (NAO) Business Office Coordinator (BOC).

Policy: All BO staff of Navajo Area are responsible to follow this guidance with the data being run form the 1st of the month and reports being due the Friday following the first Monday of every month. NOTE: Resource and Patient Management System (RPMS) Report Paths may vary from site to site. An excel template with the monthly report and the Strategic Plan will be provided to fill in your data and submit monthly to the Navajo Area Office BOC. The BO Strategic and BO Reports in the Word document will only be used for GB Meetings for reporting purposes. **Clinic/Satellite facilities will need to supplement data for the SU report.

Strategic Plan

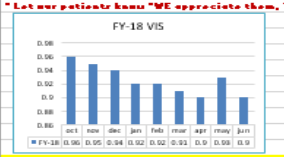
FY-2018 STRATEGIC PLAN FOR GIMC BUSINESS OFFICE FUNCTION

Patient Registration / Verification

ORAP: Timeliness of verification at time of Pt Encounter

GOAL: To verify patient eligibility, update demographics in a timely manner at first encounter and demonstrate the importance of registration role & affect on AR if not updated. This process directly affects the TP billing.

- Monitor the APL listing
- Do training on Category codes with Patient Registration and PBC to ensure all front end staff are versed on these codes for billing when entering on Pt demographics.
- Ensure each MSA is referring patients to Patient Benefit Coordinator for Alternate Resource. Assist with determination.
- Converse and compare patient encounters to ensure all patients are not missed.
- Track on a weekly, monthly, quarterly basis how many patients come to GIMC, compare to last years data. Is it increasing, decreasing? Share with staff.
- Ensure Communication is exercised at each encounter.
- Ensure we exert the "Best Customer Service" to our patients.
- Let our patients know "WE appreciate them, Thank Them".



Goal is stay above 90% in verification/Goal was met

Training Needs for Strategic Training:

- Need training on how to do comparisons on patient visits from previous FY to current FY.
- Need face to face training with each MSA to ensure all Private Insurance can be verified and updated into RPMS

Productivity Goals:

- Run Patient Errors/Warning Audit Detail report monthly
- Run and monitor VIS report. Compare with manual report.
- Do monthly in-service trainings with MSA's to ensure verification is being completed correctly.
- Do comparisons reports of patients, is this increasing or decreasing? How is this affecting our TP revenue?

Quality Goals:

- Do Audit check on MSA's work, entry, valid Pg 4 and Pg 8.
- Identify MSAs who need training on any third party insurance verification, accuracy.
- Do rounding in Clinics on MSA's to ensure verification is being completed.
- Do a competency every 120 days. Requirement for CMS.

Risk Assessment:

- Review any new Third Party Insurance, there could be denials. Track and review issues with Pt Reg, PBC, Billing, AR. There could be potential loss of revenue.
- Verification directly affects the billing/unable to transmit to third party community.

Opportunity to capitalize on:

- Review the goals/set up periodically with staff to ensure "use" are not falling out of compliance with there goals.
- Quarterly Goals and Objective review.

Effeciency:

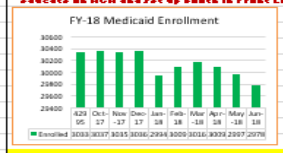
- Review the backlog of verification weekly, and how does this affect billing.
- Are MSPs being completed and entered.

Patient Benefit Coordinator/Eligibility

ORAP: To assist every patient in enrolling on some Alternate Resource and educate on the ACA

GOAL: To assist patient with TP alternate resources at time of patient encounter, and to save PBC dollars. To ensure enrollment/applications are properly completed and filed on a timely basis. *(Medicaid/Medicare)*

- Do rounding to ensure PBC is educating patients in the ACA and enrolling timely and efficiently.
- Do in-service with PBC to test knowledge on the 4 MCOs enrollment.
- Have each PBC show productivity of patients seen, enrolled with Medicaid, Medicare A, B, C and D each week.
- PBC meeting is bi-weekly for updates, ensure TOH and GIMC are sharing equal information.
- Ensure PBC is getting up outreach programs in the community, chapter house, JMI, or with GIMC to educate on ACA and set up booth in Front Lobby



Goal is to increase enrollment with Medicaid Expansion and Marketplace/Goal was met

Timeframe: MAPACA template is due each month to track

Training Needs for Strategic Training:

- PBC is a certified CAC in the circulum to enroll patients in Medicaid Expansion, Marketplace
- PBC track manually their productivity and ACA template

Productivity Goals:

- Run Exception Report of Patients over 65 without TP coverage monthly (this identifies patients who may be eligible for Medicare A, B, C and Part D)
- Run Exception Report of Patients under 18 without TP coverage monthly (this identifies patients who maybe eligible for Medicaid CHP Program).

(These tools will help increase revenue by identifying eligible populations)

Quality Goals:

- Do Audit Checks on PBC on PEMOSA applications, ensuring errors are tracked and reviewed, corrected
- Do random checks on each PBC productivity report.
- Do random check on PBC to ensure referrals are being received by Patient Registration staff.

Risk Assessment:

- Review any new Third Party Insurance, there could be denials. Track and review issues with Pt Reg, PBC, Billing, AR. There could be potential loss of revenue.
- Add new TP Insurers to capture more revenue.

Opportunity to capitalize on:

- Review the goals/set up periodically with staff to ensure "use" are not falling out of compliance with there goals.

Effeciency:

- There reports provide a tool to Managers and CEO's to monitor Benefit Coordination productivity, if we do not have our population of 3rd party resources, we can not collect additional revenue.

Coding

ORAP: Coding entered within 4 days of DOS

Goal: Coding must be entered for all services provided whether or not 3rd Party coverage is applicable.

- Ancillary Dept, visits (without a same day provider visit) must have a PCC form completed
- At least One Coder has been certified by AAPC or AHIMA
- PCC Error reports reviewed and corrected weekly
- Coding Reference books are current version
- Incomplete Coding Report - INPT is reviewed/corrected
- Incomplete Coding Report - OUTPT is reviewed/corrected
- Incomplete PCC Visits by Provider Report - INPT reviewed
- Incomplete PCC Visits by Provider Report - OUTPT reviewed
- PCC Incomplete/Error Report is reviewed weekly
- Incomplete PCC Visits by Ancillery report reviewed weekly

Coding Backlog:

- Run outpatient report by EHRD to determine the clinics uncoded daily
- Run inpatient deficiency report to determine the Providers not completing narratives/summary daily
- Quantify the uncoded amount X OMB rate $427 to determine "Potential TP reimbursement"

Timeframe: Run the EHRD and Inpatient Deficiencies, backlog of coding daily, review with staff, give out work load. Give time frame for completion.

Training Needs for Strategic Training:

- Getting more coders to be certified.
- Ensure ICD-10 training is reviewed and followed
- Review training with use of modifiers

Productivity Goals:

- Each Coder should have an expectation of set quota for coding visits per day for inpatient and outpatient
- Discriminate the workload based on the reports run for backlog.
- Run and track progress of coding every two hours to show progress.
- Do check on HIMBO to ensure these corrections do not reach 2nd and 3rd request.

Quality Goals:

- Do Audit check on coding for outpatient, inpatient visits by Certified Coder in department.
- Do random sample of Coding entries by independent certified coder for Inpatient and Outpatient coding.
- Present at Med Exec to review the deficiencies with Providers

Risk Assessment:

- Review any new Third Party Insurance, there could be denials. Track and review issues with Pt Reg, PBC, Billing, AR. There could be potential loss of revenue.

Opportunity to capitalize on:

- Review the goals/set up periodically with staff to ensure "use" are not falling out of compliance with there goals.

Effeciency:

- Review Overtime wages to determine if coding is coding all visits and bring current for billing.

Billing of TP Claims

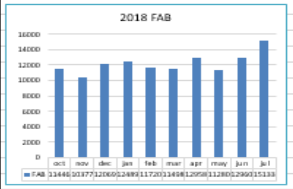
ORAP: 7 days to bill out claims

GOAL: To bill 12 Million per month/$144 Million + per FY

- Ensure Fee Schedule is updated and current.
- Outpatient billing to be within 6 days. (coding needs to stay current)
- Inpatient billing to be within 16 days (coding staying current)

Goal: To bring down to 7 days

OCT FAB:	11,446	MAY FAB:	11,280
NOV FAB:	10,377	JUN FAB:	12,960
DEC FAB:	12,069	JUL FAB:	15,133
JAN FAB:	12,489	AUG FAB:	
FEB FAB:	11,720	SEP FAB:	
MAR FAB:	11,498		
APR FAB:	12,958		



Goal

Training Needs for Strategic Training:

- Need to monitor the FAB report daily with Billing Tech.
- Need to monitor and make correct decision for Closed and Cancelled close outs.
- Ensure Billing Tech has a current Coding Book

Productivity Goals:

- Run BRRP report on Billing Technician weekly
- Run Pending Claim report daily
- Work on Error report on CHANGEHEALTH rejection report daily to ensure this is zero
- Run individual FAB for unbilled daily, review Crosswork
- Run Bills Awaiting Export report
- Run FAB and assign Crosswork, and FAB to Billing techs

Quality Goals:

- Do Audit check on Cancel and Closed report on Billing Tech. weekly to ensure there are valid.
- Do quality check on billing technician on cross training of billing all Third Party insurances.
- Review the Change Health Rejection notices daily

Risk Assessment:

- Review any new Third Party Insurance, there could be denials. Track and review issues with Pt Reg, PBC, Billing, AR. There could be potential loss of revenue.

Opportunity to capitalize on:

- Review the goals/set up periodically with staff to ensure "use" are not falling out of compliance with there goals.

Effeciency:

- Review EHRD to measure coding backlog, if any.
- Run the PSR report to review billed-collected-adjustments
- Review Overtime/Comptime wages to determine how well billing is being completed. (PRRP report)

Accounts Receivable/Posting of Payments

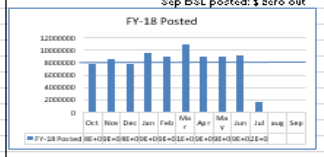
ORAP: 3 day to post from receipt of batching

GOAL: To zero out every month, post all payments in order for AoA to be received at GIMC

- Use of HIPAA standard adjustment reason codes utilized in compliance with Explanation of Benefits.

End of month NOT POSTED:

Oct BSL Posted: $7,823,475.25 zero out
Nov BSL Posted: $8,623,687.41 zero out
Dec BSL Posted: $7,769,593.71 zero out
Jan BSL Posted: $9,484,272.19 zero out
Feb BSL Posted: $8,964,801.69 zero out
Mar BSL Posted: $10,873,223.89 zero out
Apr BSL Posted: $8,584,820.37 zero out
May BSL Posted: $10,844,543.07 zero out
Jun BSL Posted: $8,563,931.98 zero out
Jul BSL Posted: $1,247,324.71 zero out
Aug BSL posted: $ zero out
Sep BSL posted: $ zero out



Timeframe: BSL report is run daily to gauge the posted amount.

Goal was met Fiscal Year 2018

Training Needs for Strategic Training:

- Need Unreconciled Training for all AR Technicians
- Need Private Insurance Interpretation of EOB for AR Technicians
- Teach the overall method of how posting turns into AoA

Productivity Goals:

- Batching to be consistent and completed Daily by Finance AR Tech
- Refunds to be consistent and completed at time of encounter on AR batch.
- Try and to be consistent with AR posting within 72 hours of receipt
- Review the Daily Totals from Finance to determine the AoA for the week
- Run Small and Large balance report, review weekly.

Quality Goals:

- Do Audit Check on posting of payment, adjustments used properly
- Do random check on Unreconciled Amounts, run UTLT report to verify amounts to be deleted, reviewed.
- Standardize posting across the board for GIMC and TOH AR Tech.

Risk Assessment:

- Review any new Third Party Insurance, there could be denials. Track and review issues with Pt Reg, PBC, Billing, AR. There could be potential loss of revenue.

Opportunity to capitalize on:

- Review the goals/set up periodically with staff to ensure "use" are not falling out of compliance with there goals.

Effeciency:

- Review Overtime wages to determine how well posting is being completed daily, and to ensure accuracy and quality.

Collections-Follow up of Denials/Claims

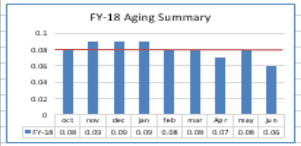
ORAP: follow up within 45 days from Posted Batch

Goal: To minimize the Aging Summary 120+ to 8%

- Each AR visit will be documented with a message outlining the reason for adjustment or reason closed.

End of Month Aging Summary:

Oct 120+:	$615,824.63	(8%)
Nov 120+:	$725,387.62	(9%)
Dec 120+:	$760,089.94	(9%)
Jan 120+:	$749,131.18	(9%)
Feb 120+:	$620,294.03	(8%)
Mar 120+:	$650,261.82	(8%)
Apr 120+:	$666,275.74	(7%)
May 120+:	$613,314.32	(8%)
Jun 120+:	$569,223.32	(6%)
Aug 120+:	$	
Sep 120+:	$	



Timeframe: To be completed Daily by 9E according to ORAP

Goal was not for FY-2018

Training Needs for Strategic Training:

- Train Voucher Examiner how to run Adjustment report and teach what is "controllable and Uncontrollable claims out.
- Train Voucher Examiner how to run Adjustment report

Productivity Goals:

- Complete Follow Up of Denials on AR Batch within same day of occurance
- Run A01 daily to review outstanding claims for denials
- Resubmissions of claims completed daily
- Work on Zero Pay batches daily-Incoming box will be ABOM office for distribution of work on ZeroPays
- Track productivity weekly of claims for adjustment, RHS
- Run USM report weekly from FY-16 to current, work claims, this directly affects the AR Metrics.

Quality Goals:

- Do Audit check on random AR Batches for correct Adjustment
- Do random check on AR messages, ensuring consistency
- Standardize across the board follow up in the same for 9E.

Risk Assessment:

- Review any new Third Party Insurance, there could be denials. Track and review issues with Pt Reg, PBC, Billing, AR. There could be potential loss of revenue.

Opportunity to capitalize on:

- Review the goals/set up periodically with staff to ensure "use" are not falling out of compliance with there goals.
- Weekly huddles to review assignments, with timeframes.

Effeciency:

- Review the resubmissions, track each week when pymt is rec'd.
- Ensure Adjustment meets the criteria on Explanation of Benefit and if it "Controllable or Uncontrollable".

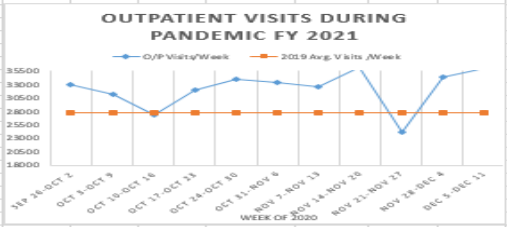
Example of Monthly & Weekly Report

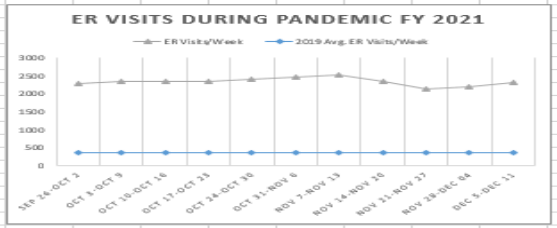
CU55

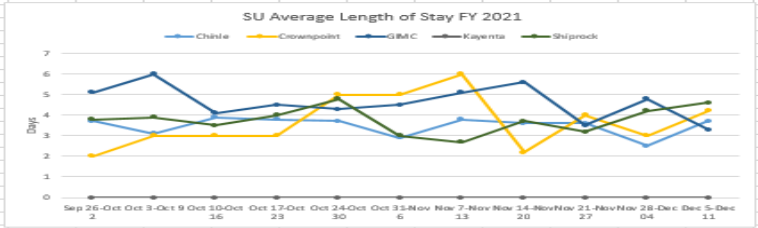
Out-Patient Visits																																				
Facility Names	ıg 2-Ma	lay 9 - 1	May 16	23-Ma	May 30	un 6-Jun 1	n 13-Jun	20-Jun	Jun 27	Jul 4-10	Jul 11-17	ul 18-24	ul 25-3	Aug 1-7	Aug 8-1	Aug 15	ug 22-2	g 29-Sep	5-Sep	Sept 12	19 -Sep	26-Oct	3-Oct	10-Oct	17-Oct	24-Oct	31-Nov	7-Nov	14-Nov	21-Nov	28-Dec	5-Dec	11			
Chinle	4849	4738	4940	4582	4421	5241	4501	5199	5029	4336	4680	5482	5152	5335	6401	6696	6269	6060	5278	5581	5856	5948	5826	6120	6383	6643	6454	6545	6493	5353	7770	6847				
Tsaile	599	647	720	550	455	745	502	664	501	459	586	706	679	702	747	720	815	722	679	723	829	830	951	869	971	996	742	723	1072	636	810	814				
Pinon	677	805	966	868	646	934	744	1041	907	764	870	1030	929	1207	1143	1297	1221	1106	1019	1309	1309	1271	891	1006	1283	1456	1107	1325	1241	902	1339	1147				
Crownpoint	1618	1553	1758	1668	1444	1673	1633	1572	1524	1375	1704	1520	1510	1811	1788	1743	1878	2093	1723	1858	1503	1741	1646	1538	1827	1937	1936	1706	1884	1351	1339	1677				
Thoreau	239	288	291	331	224	344	270	407	330	287	388	344	342	387	306	306	348	307	272	325	389	331	373	312	371	408	296	168	353	237	330	414				
Pueblo Pintado	270	314	291	207	170	326	236	314	317	221	313	343	336	335	258	327	263	240	217	288	323	255	221	217	333	346	347	221	401	282	339	371				
GIMC	7849	7832	7562	7486	6972	6950	7182	7168	7146	6443	7545	7545	7638	7809	7892	7,892	9,572	9,231	8,208	8,666	9,023	9,246	9,334	7478	9652	9252	9306	9078	10740	6334	9674	8515				
Tohatchi	424	454	484	448	305	427	334	428	357	454	454	454	562	535	504	504	707	568	426	706	609	918	543	479	579	640	662	552	727	438	678	681				
Kayenta	1589	1866	2138	1937	1720	2028	1699	2106	1740	1494	1835	1849	1811	1951	1982	1823	2339	2098	1701	1927	2214	2186	1913	1867	1839	2253	2299	2299	2435	1418	2389	1865				
Inscription House (IHHC)	273	289	371	351	274	379	224	341	344	355	289	367	348	373	287	388	464	335	296	359	278	277	273	357	382	406	370	370	467	283	376	322				
Dennehotso	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0				
Shiprock	5,176	5,714	5,954	6,354	4,761	5,521	4,710	4,970	5,272	5909.2	5052	5356	5362	5591	5943	6,299	6,869	7,450	5,594	6,110	7,410	8,492	7,895	5,968	7,188	8,109	7,975	8,271	8,998	6,020	7,880	11,758				
Dzilth-Na-O-Dith-Hle (DZ)	318	304	379	404	291	301	235	330	307	282.7	293	286	333	338	343	440	394	473	292	388	338	423	437	351	402	544	410	444	463	318	465	386				
Red Mesa	714	781	814	669	597	831	672	782	711	738.36	771	778	678	714	804	838	793	881	690	956	875	966	717	710	817	892	825	813	940	601	995	1,105				
O/P Visits/Week	24595	25585	26668	25853	22280	25700	22942	25322	24485	23118	24780	26060	25680	27088	28404	29269	31932	31564	26317	29196	30956	32884	31080	27272	32027	33882	33331	32515	36214	24173	34384	35902				
2019 Avg. Visits /W	27846	27846	27846	27846	27846	27846	27846	27846	27846	27846	27846	27846	27846	27846	27846	27846	27846	27846	27846	27846	27846	27846	27846	27846	27846	27846	27846	27846	27846	27846	27846	27846				

Visits																																				
Facility Names	Apr 25	May 2-1	lay 9 - 1	May 16	May 23	May 30-J	Jun 6-J	Jun 13-	Jun 20-	Jun 27	Jul 4-10	Jul 11-17	ul 18-24	ul 25-3	Aug 1-7	Aug 8-1	Aug 15	ug 22-2	g 29-Sep	5-Sep	Sept 12	Sept 19	p 26-Oct	3-Oct	10-Oct	17-Oct	24-Oct	31-Nov	7-Nov	14-Nov	21-Nov	28-Dec	5-Dec	11			
Chinle	212	205	180	193	176	209	210	200	202	186	228	424	450	448	541	577	550	532	480	472	478	430	417	433	434	463	462	465	467	479	438	450	439			
Crownpoint	229	216	232	248	224	221	241	220	227	205	210	219	214	242	277	241	255	229	264	295	274	215	245	248	268	265	274	252	253	232	192	235	238			
GIMC	590	606	581	613	588	604	554	582	578	632	669	591	591	699	764	796	796	836	860	877	813	813	812	836	779	738	793	903	885	825	710	753	688			
Kayenta	253	255	250	245	256	257	246	268	266	227	355	289	267	277	275	314	317	373	313	313	274	231	259	288	289	326	295	263	308	285	265	304	259			
Shiprock	437	438	426	447	399	470	411	452	436	417	678	446	459	413	485	482	522	614	587	562	543	495	562	539	591	572	594	589	608	520	543	461	705			
ER Visits/Week	1721	1720	1669	1746	1643	1761	1662	1722	1709	1667	2140	1969	1981	2079	2342	2410	2440	2584	2504	2519	2382	2184	2295	2344	2361	2364	2418	2472	2521	2341	2148	2203	2329			
2019 Avg. ER Vis	363	363	363	363	363	363	363	363	363	363	363	363	363	363	363	363	363	363	363	363	363	363	363	363	363	363	363	363	363	363	363	364	364			

ALOS																																				
Facility Names	May 16	May 23	May 30	Jun 6-J	Jun 13-	Jun 20-J	Jun 27-	Jul 4-10	Jul 11-17	Jul 18-	Jul 25-3	Aug 1-7	Aug 8-1	Aug 15	ug 22-2	g 29-Sep	5-Sep	Sept 12	Sept 19	p 26-Oct	3-Oct	10-Oct	17-Oct	24-Oct	31-Nov	7-Nov	14-Nov	21-Nov	28-Dec	5-Dec	11						
Chinle	3.1	2.4	2.2	2.8	4.8	4.9	3.4	3	4.4	1.8	4.6	3.6	4	2.9	4.3	2.9	4.1	2.7	2.9	3.7	3.1	3.9	3.8	3.7	2.9	3.8	3.6	3.6	2.5	3.7						
Crownpoint	4	2	3	3	3	2	2	2	4	2	2	2	2	7	4	3	3	4	2	2	3	3	3	5	5	6	2.2	4	3	4.2						
GIMC	4.8	3.5	2.8	4.3	3.1	4.3	3.7	3.8	4.4	4.4	6.0	4.8	5.7	5.7	4.4	6.2	6.6	5.5	4.5	5.1	6	4.1	4.5	4.3	4.5	5.1	5.6	3.5	4.8	3.3						
Kayenta	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0						
Shiprock	3	2.8	3.7	3.7	4.9	1.8	3.7	3.7	4	2.9	3.7	4.9	5.1	4.0	1.7	2.9	2.3	3.4	4.7	3.8	3.9	3.5	4	4.8	3	2.7	3.7	3.2	4.2	4.6						







Visits-OP.ER,ALOS | Disch.Admss | Billing-Bill.Coll | TeleHealth.Med | Tele-Behavioral Health | VA

Moving Forward-Positives

Teamwork

QI Training

Communication

Motivation

Quality Improvement

Data-Driven Decisions

Templates Identified

Transparency

Planning

Control Practices

Analysis

Process Management

Framework

Employee Involvement

System

Policies & Procedures Created

Moving Forward-Challenges

- “This is how we always done it” mentality
- Non-communication from Upper Management to Lower Management
- Lack of QI Training
- Lack of QI Knowledge/Terminology
- Expectations/Outcomes not clearly defined
- No Buy-in

Questions?

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Indian Health Service


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